TFA document

Supporting all NHS Trusts to achieve NHS Foundation Trust status by April 2014

Tripartite Formal Agreement between:

- North Bristol NHS Trust
- NHS Bristol
- Department of Health

Introduction

This Tripartite Formal Agreement confirms the commitments being made by the NHS Trust, their Strategic Health Authority and the Department of Health that will enable achievement of NHS Foundation Trust status before 1 April 2014.

Tripartite Formal Agreements are made up of nine parts, each of which is introduced below.

Part 1

Part 1 confirms the date when the NHS Trust will submit its 'NHS Foundation Trust ready' application to the Department of Health to begin their formal assessment towards achievement of NHS Foundation Trust status.

Part 2

The organisations signing up to this agreement are confirming their commitment to the actions required by signing in Part 2a. The signatories for each organisation are as follows:

- NHS Trust – Chief Executive;
- Strategic Health Authority – Chief Executive;
- Department of Health – Ian Dalton, Managing Director of Provider Development.

Prior to signing, NHS Trust Chief Executives should have discussed the proposed application date with their Board to confirm support. In addition the lead commissioner for the NHS Trust will sign in Part 2b to agree support of the process and timescales set out in the agreement.

The information provided in this agreement does not replace the SHA assurance processes that underpin the development of FT applicants. The agreed actions of all SHAs will be taken over by the National Health Service Trust Development Authority (NTDA) NTDA previously known as the Provider Development Authority – the name change is proposed to better reflect their role with NHS Trusts only when they take over the SHA provider development functions.

Part 3

Part 3 sets out the services provided by the NHS Trust, its commissioners, the financial context and key quality and performance issues.

Part 4

Part 4 sets out the key strategic and operational issues facing each NHS Trust.

Part 5

Part 5 sets out the key actions to be taken by the NHS Trust to address the key strategic and operational issues facing the NHS Trust.

Part 6

Part 6 sets out the key actions to be taken by the Strategic Health Authority to address the key strategic and operational issues facing the NHS Trust.

Part 7

Part 7 sets out the key actions to be taken by the Department of Health to address the key strategic and operational issues facing the NHS Trust.

Part 8

Part 8 of the agreement sets out the key milestones that will need to be achieved to enable the NHS Foundation Trust application to be submitted to the date in Part 1 of the agreement.

Part 9

Part 9 sets out the key risks to delivery of the NHS Foundation Trust application to the date set out in Part 1 of the agreement.

The guidance provided by the Department of Health for the preparation of Tripartite Formal Agreements is set out in Appendix 1.

Standards required to achieve NHS Foundation Trust status

The establishment of a Tripartite Formal Agreement for each NHS Trust does not change, or reduce in any way, the requirements needed to achieve NHS Foundation Trust status.

That is, the same exacting standards around quality of services, governance and finance will continue to need to be met, at all stages of the process, to achieve NHS Foundation Trust status. The purpose of the Tripartite Formal Agreement for each NHS Trust is to provide clarity and focus on the issues to be addressed to meet the standards required to achieve NHS Foundation Trust status. The Tripartite Formal Agreement should align with the local quality and productivity agenda.

Alongside development activities being undertaken to take forward each NHS Trust to NHS Foundation Trust status by 1 April 2014, the quality of services will be further strengthened. Achieving NHS Foundation Trust status and delivering quality services are mutually supportive. The Department of Health is improving its assessment of quality. Monitor has also been reviewing its measurement of quality in their assessment and governance risk ratings. To remove any focus from quality healthcare provision in this interim period would completely undermine the wider objectives of all NHS Trusts achieving NHS Foundation Trust status, to establish autonomous and sustainable providers best equipped and enabled to provide the best quality services for patients.

Part 1 - Date when NHS foundation trust application will be submitted to Department of Health

1 April 2012

Part 2a - Signatories to agreements

By signing this agreement the following signatories are formally confirming:

- their agreement with the issues identified;
- their agreement with the actions and milestones detailed to support achievement of the date identified in part 1;
- their agreement with the obligations they, and the other signatories, are committing to;

as covered in this agreement.

Ruth Brunt, Chief Executive, North Bristol NHS Trust	 Date: 23 September 2011
Sir Ian Carruthers OBE, Chief Executive, South West Strategic Health Authority	 Date: 30 September 2011
Ian Dalton, Managing Director, Provider Development, Department of Health	 Date: 30 September 2011

Part 2b – Commissioner agreement

In signing, the lead commissioner for the Trust is agreeing to support the process and timescales set out in the agreement.

Deborah Evans, Chief Executive, NHS Bristol	 Date: 29 September 2011

Part 3 – NHS Trust summary

Short summary of services provided, geographical/demographical information, main commissioners and organisation history.

Required information
Current CQC registration is registered without conditions

Financial data

	2009/10	2010/11
Total income	£473.815m	£492.883m
EBITDA	£33.2m	£39.1m
Operating surplus\deficit	£6.177m	£7.888m
CIP target	£19.6m	£24.2m
CIP achieved recurrent	£18.6m	£23.2m
CIP achieved non-recurrent	£1.2m	£5.5m

North Bristol NHS Trust (NBT) is a large teaching hospital with a major and growing research portfolio, It had turnover of £493m in 2010/11 and a surplus before impairments of £7.9m.

Services are currently provided from two large, acute hospitals 5 miles apart; Southmead Hospital and Frenchay Hospital. Children's community health and CAMHS services across Bristol and South Gloucestershire are also provided, and the Trust took on South Gloucestershire adult community services from April 2011. It is in the process of concentrating its acute services on the Southmead site through the construction of a new PFI funded hospital due to open in April 2014. The Frenchay site will then provide facilities for a community hospital.

The Trust provides a full range of secondary acute and community care to its local catchment population of 425,000 across Bristol, South Gloucestershire and North Somerset. It is also a very significant provider of tertiary services to a wider population of around 3m across the South and West, with a specialist commissioning contract of £110m.

Frenchay focuses on urgent care with a full Emergency Department, Neurosciences, Plastic Surgery and Burns and is the major trauma centre for the north of the region. Southmead takes GP emergency admissions and has a minor injury unit, but focuses on elective care together with maternity, NICU, renal and pathology services. The lead commissioner for the trust is NHS Bristol.

Part 4 – Key issues to be addressed by NHS trust

Key issues affecting NHS Trust achieving FT	
Strategic and local health economy issues	
Service reconfigurations	☒
Site reconfigurations and closures	☒
Integration of community services	☒
Not clinically or financially viable in current form	☐
Local health economy sustainability issues	☒
Contracting arrangements	☒
Financial	
Current financial Position	☐
Level of efficiencies	☒
PFI plans and affordability	☒
Other Capital Plans and Estate issues	☒
Loan Debt	☒
Working Capital and Liquidity	☒
Quality and Performance	
QIPP	☐
Quality and clinical governance issues	☐
Service performance issues	☐
Governance and Leadership	
Board capacity and capability, and non-executive support	☐

Please provide any further relevant local information in relation to the key issues to be addressed by the NHS Trust:

Service and site reconfiguration – further acute service reconfiguration
In accordance with the Bristol Health Services Plan of 2005 - which sets out the strategic direction for the local health community - reconfiguration of acute services has been ongoing across the city to optimise the delivery of efficient, high quality care in certain specialities. The 2005 reconfiguration plan taken with the Trust's planned productivity improvements and the wider health community QIPP plans is projected to leave spare capacity within the new PFI hospital of at least 100 beds. The Trust's long term financial model assumes a transfer of acute services to NBT broadly equivalent to the transfers already planned to University Hospitals Bristol (UHB), in order that this capacity is fully utilised.

Integration of Community Services
The transfer of the South Gloucestershire Community Services to NBT took place on 1 April 2011. The transfer was delivered on time with no significant issues.

Local Health Community sustainability Issues
NHS South Gloucestershire commissions 80% of its acute services from NBT and has a significant financial challenge, being classified as a category B organisation by the DH in the context of 2011/12 operational planning. It needs to reduce spend in the acute sector. This also applies to NHS Bristol which has a lesser but still significant financial challenge, and to NHS North Somerset, but the Trust has a much smaller contract with the latter (7.5% of total PCT income). Commissioning envelopes were agreed for 2011/12 which required NBT QIPP of c £13m (5%) across the local health community, with no provision for growth. To date, this level of QIPP looks unlikely. The plans to deliver this still require further development. There is likely to be a QIPP overhang from this, together with UHB QIPP, into 2012/13 which, if achieved, would substantially resolve the commissioner affordability issue.

Potential Merger
There have been ongoing discussions in regard to the potential merger of North Bristol NHS Trust with University Hospitals Bristol NHS Foundation Trust, The Tripartite Formal Agreement reflects the process for North Bristol NHS Trust becoming a stand alone NHS Foundation Trust.

Contracting arrangements
The Trust has been seeking to rebase non-PbR tariffs, but this has not yet been agreed by commissioners. It is important for the security of the Trust's income that rebasing is agreed during 2011/12 for implementation in 2012/13.

Level of Trust efficiencies/QIPP
Annual efficiency savings in excess of 6% per annum are required for the next three years to build up a surplus sufficient to cover the net cost of the new hospital, and then 7.9% in 2014/15 including the savings associated with the new hospital. The scale of this means that transformation of care pathways in some areas will be needed, with agreement on new tariff currencies to share the benefit between the Trust and commissioners.

PFI plans and affordability - impact of the PFI scheme on compliance with prudential borrowing limits (PBL)
Under the current long-term financial model, when the new PFI hospital opens in 2014 the Tier 2 prudential borrowing limit is breached based on application of the Tier 2 ratios, notwithstanding a planned EBITDA of over 12% of turnover, which is at the top end of FT performance nationally. However, the guidance on prudential borrowing limits indicates that on the opening of the new hospital, a PBL equivalent to the Trust's borrowing at the time would be factored in, and so this will not affect the Trust's financial risk rating.

PFI plans and affordability - securing agreed non-tariff funding streams associated with the new hospital
Four non-recurring funding streams outside tariff were agreed with South West Strategic Health Authority and local commissioners as part of the approvals for the new hospital; new hospital transitional funding, funding to support accelerated depreciation associated with the new hospital, funding from commissioners to support the PFI scheme going on balance sheet and funding from the SHA also supporting the impact of on balance sheet accounting. The SHA will work with the Trust to ensure that the new hospital income streams are secured in the transition to the new SHA structures.

Loan debt
The Trust repaid £34m of its £52m historic debt at March 2011, in line with the agreed repayment profile. Repayment of the remaining £18m is scheduled over 2011/12 and 2012/13. This is dependent on receipt of the commissioner support agreed in the original debt repayment plan - £4.8m in 2011/12 and £4.7m in 2012/13.

Working capital and liquidity
As a consequence of retained surpluses and capital receipts over the last 4 years necessarily being used to fund the £34m historic debt repayment rather than being available to improve liquidity, the Trust has a low liquidity ratio, with a liquidity risk rating of 1. This results in a limiting of the overall financial risk rating to a maximum of 2, irrespective of EBITDA and retained surplus performance. The liquidity score is forecast to increase to 2 from March 2012.

Other capital plans and estate issues
There are remaining capital expenditure requirements outside the PFI scheme to support the new hospital scheme. These need to be financed while meeting the liquidity improvement requirement outlined above. The Trust has an outline plan for doing this within its LTFM, but this does not yet address all the requirements fully.

MRSA Performance
There have been nine cases of MRSA against the annual target of eight. The Trust has drawn up a recovery plan which has been agreed with the PCT and SHA. Second quarter

performance has returned to an acceptable trajectory. The Trust must demonstrate that this improved performance is sustained.

Part 5 – NHS Trust actions required

Key actions to be taken by NHS Trust to support delivery of date in part 1 of agreement

Strategic and local health economy issues	
Integration of community services	☒
Financial	
Current financial position	☐
CIPs	☐
Other capital and estate Plans	☒
Quality and Performance	
Local / regional QIPP	☒
Service Performance	☒
Quality and clinical governance	☐
Governance and Leadership	
Board Development	☐
Other key actions to be taken (please provide detail below)	☒

Describe what actions the Board is taking to assure themselves that they are maintaining and improving quality of care for patients.

Strategic and local health economy issues - Community Services transfer
Achieve successful transfer with no major unexpected issues emerging
Director of Operations - September 2011 (Complete)..

Local/regional QIPP – detailed planning for level of Trust efficiencies
Develop a four year transformational change plan that delivers the required efficiency savings, predominantly through developing the work under the Building our Future programme, with appropriately greater detail for years 1 and 2. Director of People, Performance and Operations Director and Director of Finance – first cut plan by June 2011 and final plan by December 2011.

Local health community commissioning QIPP plans
Work with commissioners to put greater detail on the existing QIPP plans to reduce the use of the acute sector during 2011/12. Take actions falling to the Trust within the detailed plan to support delivery of the required reductions, and reduce acute capacity and cost in line with the plan. DoF and Director of Operations – detailed plan by June 2011, delivery during 2011/12 to March 2012.

Other capital and estate plans - meeting essential requirements while improving liquidity sufficient to support FT application
Develop a more detailed and complete capital investment plan that meets these two requirements. Director of Finance – June 2011 (Complete).

Other
Delivery of 2011/12 financial plan, and associated debt repayment. Director of Finance – ongoing.

MRSA
Deliver the recovery plan to bring the number of monthly MRSA cases back below the national target.

Part 6 – SHA actions required

Key actions to be taken by SHA to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Local health economy sustainability issues (including reconfigurations)	☐
Contracting arrangements	☐
Transforming Community Services	☐
Financial CIPs\efficiency	☐
Quality and Performance Regional and local QIPP	☐
Quality and clinical governance	☐
Service Performance	☐
Governance and Leadership Board development activities	☐
Other key actions to be taken (please provide detail below)	☒

Please provide any further relevant local information in relation to the key actions to be taken by the SHA with an identified lead and delivery dates.

The SHA is contributing to the national work on PFI and will work with the Trust in resolving the outstanding PFI issues as a result of the national financial review.

Part 7 – Supporting activities led by DH

Actions led by DH to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Alternative organisational form options	☐
Financial NHS Trusts with debt	☐
Short/medium term liquidity issues	☐
Current/future PFI schemes	☒
National QIPP workstreams	☐
Governance and Leadership Board development activities	☐
Other key actions to be taken (please provide detail below	☐

Please provide any further relevant local information in relation to the key actions to be taken by DH with an identified lead and delivery dates:

A national financial review of Trusts with a PFI hospital is taking place to gain a common understanding of any issues that might be an obstacle to passing the financial elements of the FT assessment process. Some elements contained within the TFA will be subject to the outcome of this review in enabling any issues outlined in this agreement to be resolved. This will be confirmed on a case by case basis as the PFI work is completed and communicated.

Part 8 – Key milestones to achieve actions identified in parts 5 and 6 to achieve date agreed in part 1

Date	Milestone
1 July 2011	First draft IBP and LTFM
July 2011	Consultation begins
October 2011	Historical Due Diligence part one
December 2011	MRSA recovery plan on track
January 2012	Final IBP and LTFM
January 2012	Commissioner convergence letter
February 2012	Historical Due Diligence part two
March 2012	Board to Board
April 2012	Application to DH

Key milestones will be reviewed every quarter, so ideally milestones may be timed to quarter ends. The milestones agreed in the above table will be monitored by senior Department of Health and Strategic Health Authority leaders until the NHS Trust Development Authority takes over formal responsibility for this delivery. Progress against the milestones agreed will be monitored and managed at least quarterly, and more frequent where necessary as determined by the Strategic Health Authority (or NHS Trust Development Authority subsequently). Where milestones are not achieved, the existing Strategic Health Authority escalation processes will be used to performance manage the agreement. (This responsibility will transfer to the NHS Trust Development Authority once it formally has the authority).

Part 9 – Key risks to delivery

Risk	Mitigation including named lead
Lack of agreement on acute service transfers that ensure that the new hospital is fully utilised	Commissioner and SHA involvement to ensure resolution. Lead Exec at NBT – CEO
Insufficient clarity on content of 4 year efficiency savings plan	Seek additional resources including potentially external support to complete the plan. Lead Execs – DoF and Director of People, Performance and OD.
Technical breach of Tier 2 PBL is obstacle to FT	Increased EBITDA well over 12% would then be only means of achieving FT, but this would not be realistic. Lead Exec – DoF
Failure to draw up a plan that achieves liquidity improvement while meeting essentially capital investment requirements	Seek off balance funding for an element of the capital plan. Lead Exec – DoF
Failure to secure agreed non-tariff funding streams to support the new hospital scheme	Commissioner and SHA involvement to ensure resolution. Lead Exec - DoF
Failure to deliver recovery plan on MRSA	Performance management of recovery plan and regular reporting to Board. Lead Exec – Medical and Nursing Directors